



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

TOTAL FAMILY CHIROPRACTIC CLINIC INC  
PO BOX 700311  
SAN ANTONIO TX 78270-0311

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

CASTLEPOINT NATIONAL INSURANCE

#### **Carrier's Austin Representative Box**

Box Number 17

#### **MFDR Tracking Number**

M4-11-0958-01

#### **MFDR Date Received**

November 16, 2010

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary as stated on the Table of Disputed Services:** "Medical necessity established"

**Amount in Dispute:** \$4,212.61

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Enclosed please find a copy of a Peer Review...dated 3/12/2009. In his review, [chiropractor] clearly indicates that "...chiropractic manipulation is considered unnecessary, unreasonable, and unrelated to the compensable injury occurring on 12/3/2008 and the diagnosis identified. Physical therapy at this late date is also unnecessary and unrelated to the compensable injury as the ODG Treatment Guidelines specifically indicate 9 visits over 8 weeks, and the examinee is approximately 12 weeks post inquiry...Further, it is the Carrier's position that pre-authorization for treatment received was not obtained..."

**Response Submitted by:** SUA Insurance Company; PO Box 154110; Irving TX 75015

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2009 to March 18, 2010 September 18, 2009 January 8, 2010	CPT codes 99204, 99213, 99212	\$1,268.65	\$0.00
February 25, 2010	CPT code 97750-FC	\$ 875.95	\$0.00
September 14, 18, 2009 November 24, 2009	CPT codes 97110, 97140	\$620.19	\$589.80
January 8, 2010	CPT codes 95900-59, 95903-59, 95904-59, 95861, HCPCS codes A4556, A4215, A4558	\$1,447.82	\$0.00
Total Due			\$589.80

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §137.100 sets out the treatment guidelines in accordance with the Official Disability Guidelines (ODG).
5. 28 Texas Administrative Code §134.600 requires preauthorization for non-emergency health care.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 6, 2009 through April 24, 2010

- 216 – based on the findings organization
- 855-020 – reimbursement has been denied based upon the recommendation of a peer review
- 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 880-104: Denied per insurance: unnecessary treatment

Explanation of benefits dated February 25, 2010

- 197 – precertification/preauthorization /notification absent
- 855-024 – service is denied for lack of proof of preauthorization

### **Issues**

1. Has the extent of injury issue been resolved?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307? Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Did the respondent support its denial reasons of "216" and "855-020" ?
4. Did the respondent supports its denial reasons of "197" and "855-024"?
5. Is the requestor entitled to reimbursement?

### **Findings**

1. A Benefit Dispute Agreement (DWC-24) was signed on March 18, 2010 to resolve that the compensable injury of December 3, 2008 does extend to include a C6/C7 herniated nucleus pulposus (HNP). The parties also agree the injury does not extend to include C2/C3, C3/C4, C4/C5 and C5/C6 disc protrusions. Therefore, the extent of injury issues have resolved and the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
2. The requestor billed CPT codes 99204, 99213, and 99212 on various dates of service in this medical fee dispute. The requestor also billed CPT code 97750-FC. The respondent denied these services with denial reason codes "216 – based on the findings organization", "855-020 – reimbursement has been denied based upon the recommendation of a peer review", "50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer", and "880-104: Denied per insurance: unnecessary treatment." 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution.

Review of the submitted documentation finds unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution. The requestor has failed to support that these services (99204, 99213, 99212, and 97750-FC) are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment for these services.

3. The respondent denied payment for CPT codes 97110 and 97140 with denial reason codes “216 – based on a peer review” and “855-020 – reimbursement has been denied based upon the recommendation of a peer review.” 28 Texas Administrative Code §134.600 (c) states, “The carrier is liable for all reasonable and necessary medical costs relating to the health care (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care.”

The requestor submitted preauthorization letters dated September 10, 2009 and October 28, 2009 both approving two visits each for CPT codes 97110 and 97140. Therefore, the respondent's denial reasons are not supported and the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.

4. The respondent denied payment for CPT codes 95900, 95903, 95904, 95861, A4556, A4558, and A4215 with denial reason codes “197” and “855-024”. 28 Texas Administrative Code §137.100(a) states in pertinent part “(a) Health care providers shall provide treatment in accordance with the current edition of the Official Disability Guidelines - Treatment in Workers' Comp, ...unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title...”

Review of 28 Texas Administrative Code §134.600 finds that preauthorization is not required for nerve conduction tests and needle electromyography. For that reason, the services/treatments in dispute are subject to the ODG. Review of the January 2010 Shoulder chapter finds that these treatments are not addressed.

According to §137.100 (f) “A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title...” The requestor did not submit documentation to support that preauthorization was obtained. Therefore, the respondent's denial reason is supported.

5. The requestor is eligible for reimbursement as follows:

- CPT code 97110: WC CF \$53.68 ÷ Medicare CF \$36.0666 x participating amount \$26.83 = \$39.93 x 4 units = \$159.73 x 3 days = \$479.19
- CPT code 97140: WC CF \$53.68 ÷ Medicare CF \$36.0666 x participating amount \$24.77 = \$36.87 x 3 days = \$110.61

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for CPT codes 97110 and 97140 only. As a result, the amount ordered is \$589.80.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$589.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

		July , 2012
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**